Medical Health Questionnaire **InVision Perio**

Name: ______________________________ **Age:** ____ **Height:** _____ **Weight:** ______

Physician List (*please list your primary physician and any medical specialists you see*)

Name	City & Phone #	SPECIALTY	Date of Last Exam

Please list all pills, medications, herbs, and drugs that have been prescribed for you and ALL others that you take:

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Circle **Yes** or **No** for the following questions:

Have you been prescribed, are you taking, or have you ever taken any **bone sparing** or **bisphosphonate drugs**? Fosamax,Boniva, Actonel, Didronel, Zometa, Reclast, Prolia?	YES NO	**ALLERGIES/REACTIONS TO drugs, medications, anesthetics, materials?** Please list:	YES NO
EPINEPHERINE REACTION	YES NO	**LATEX ALLERGY**	YES NO
TMD/TMJ PROBLEMS	YES NO	**ANAPHYLAXIS**	YES NO
Are you pregnant or possibly pregnant? How many weeks:	YES NO YES NO	Taking Birth Control? Breast Feeding?	YES NO YES NO
Have you been hospitalized in the Past 2 years? If yes, what condition?	YES NO	Have you ever had a serious illness? If yes, Please list:	YES NO
Have you had Cancer? If yes, what type:	YES NO YES NO	Radiation therapy? Chemotherapy?	YES NO YES NO
Are you taking anticoagulant drugs?	YES NO	Are you on Steroid therapy?	YES NO
Do you use any type of tobacco? If yes, type: How often:	YES NO YES NO	Any drug or alcohol addiction? Drug or Alcohol use? How many times per week:	YES NO YES NO

Circle **Y** for **Yes** or **N** for **No**

Asthma	Y N	Endocarditis	Y N	Hives/Rash	Y N	Parathyroid Disease	Y N
AIDS/HIV+/ARC	Y N	Enlarged Heart	Y N	Immunosuppression	Y N	Persistent Cough	Y N
Alzheimer's	Y N	Epilepsy/Seizures	Y N	Intestinal Disease	Y N	Psychiatric Care	Y N
Anemia	Y N	Excessive Bleeding	Y N	Irritable Bowel (IBS)	Y N	Renal Dialysis	Y N
Angina	Y N	Fainting/Dizziness	Y N	Irregular Heart Beat	Y N	Rheumatic Fever	Y N
Arthritis	Y N	Glaucoma	Y N	Jaundice	Y N	Sinus Problems	Y N
Artificial Valves	Y N	Gout	Y N	Joint Pain/Swelling	Y N	Stomach Problems	Y N
Artificial Joint Replacement Date?	Y N	Diabetes Avg.Blood Sugar	Y N	Kidney Problems	Y N	Stroke	Y N
Bruise Easily	Y N	Heart Attack	Y N	Leukemia	Y N	Thyroid Disease	Y N
Blood Disease	Y N	Heart Murmur	Y N	Liver Disease	Y N	Tuberculosis	Y N
Cold Sores	Y N	Heart Pacemaker	Y N	Low Blood Pressure	Y N	Tumors/Growths	Y N
Congenital Heart Lesions	Y N	Heart Problems	Y N	Lung Disease	Y N	Ulcers	Y N
Convulsion	Y N	Heart Surgery	Y N	Lupus	Y N	Anxiety	Y N
Cortisone/Steroids	Y N	Hepatitis	Y N	Mitral Valve Prolapse	Y N	Hearing Difficulty	Y N
Chest Pain	Y N	Herpes	Y N	Mental Difficulties	Y N	Dental Fear	Y N
Emphysema	Y N	High Blood Pressure	Y N	Neck/Back Pain	Y N	Multiple Sclerosis	Y N

Have you ever been directed to take antibiotics prior to any dental treatment? YES NO

If you answered yes to the above question, what antibiotic was prescribed and for what condition?

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Do you have any problem, condition or disease not listed above? YES NO If YES, explain:

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Have you gone to the hospital or emergency room, or had a serious illness in the last three years? **YES NO**

If YES, explain: ____

Are you currently being treated by a physician for any medical conditions? **YES NO**

If YES, explain: ____

Whom would you like us to contact in case of an emergency?

Name: ____________________ **Relationship:** ______________ **Phone Number:** ______________

The practice of dentistry involves treating the whole person. If our doctors determine that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the doctor to contact my physician.

To the best of my knowledge, the questions on this form have been answered accurately. I understand that withholding or providing incorrect information may be dangerous to my (or the patient's) health. I also agree to inform the doctor and/or staff of any changes in my (or the patient's) medical status.

________________________________ ________ ____________________

Signature of Patient, Parent or Legal Guardian Date Reviewed by

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MEDICAL UPDATES

I have reviewed my Medical History and confirm that it accurately states past and present conditions.

Date	Patient's Signature	Changes to Health History	Dr. Initials

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OFFICE USE

BP_______ **PULSE** ______ **DATE** ________ **BP**_______ **PULSE** ______ **DATE** ________

BP_______ **PULSE** ______ **DATE** ________ **BP**_______ **PULSE** ______ **DATE** ________